

## Frequently Asked Questions – Reporting Surgical Treatment for Morbid Obesity

1. *To determine if a surgical treatment must be reported, please answer questions a., b., and c. below.*

- a. *Was the procedure performed one of the following?*

Current Procedural Terminology (CPT) Codes:

- 43644** Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)
- 43645** Laparoscopic, gastric restrictive surgery, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) with small bowel reconstruction to limit absorption
- 43770** Laparoscopic surgical gastric restrictive procedure. Placement of adjustable gastric band
- 43842** Gastric restrictive procedure, without gastric bypass; vertical-banded gastroplasty (VBG)
- 43843** Gastric restrictive procedure, other than vertical-banded gastroplasty
- 43845** Biliopancreatic diversion with duodenal switch
- 43846** Gastric restrictive surgery, with gastric bypass for morbid obesity; with short limb (150 cm or less) Roux-en-Y gastroenterostomy
- 43847** Gastric restrictive surgery, with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less) with small bowel reconstruction to limit absorption
- 43848** Revision of gastric restrictive procedure for morbid obesity (separate procedure)

If the answer is no, there is no need to report this surgery.

If the answer is yes, please answer questions b. and c.

- b. *For the procedures listed above, was this the first surgery this patient has had related to morbid obesity? If yes, was this surgery performed on or after **July 1, 2006**? If the answer is yes, this surgery must be reported.*
- c. *If this was not the first surgery this patient has had related to morbid obesity, was this surgery performed due to a complication or side effect of the initial surgery? If yes, was the initial surgery one of the above procedures that was performed on or after **July 1, 2006**? If the answer is yes, this surgery must be reported as a follow-up report to the initial surgery.*

2. *Which follow-up visits do I report?*

If the patient's initial (first or only) surgery for morbid obesity was performed on or after **July 1, 2006**, follow-up visits must be reported at 30, 60, 90 days, and 1 year after that initial surgery.

**Note: Do not report follow-up visits on patients whose initial surgery was performed before July 1, 2006. Do not report additional visits that take place between the required follow-up intervals. Do not report follow-up after one year unless death or a complication/side effect of surgery resulting in permanent disability has occurred. Use the appropriate annual report for those events.**

It is understood that the patients' and physicians' schedules may not permit scheduling follow-up visits at precisely these intervals. It is also understood that, at times, patients may cancel or fail to appear for scheduled follow-up visits. Report follow-up visit information that is available. For example, if the patient schedules a visit at 40 rather than 30 days, report information from that visit as the 30-day follow-up and note the date of the follow-up in the comment box in Section 3.

3. *We usually see our patients at different follow-up intervals than those on the form. How do we report our follow-up visits?*

Many patients will be seen for follow-up before 30 days, between the prescribed intervals, and at various intervals after the first year. You are required to report information from follow-up visits at 30, 60, and 90 days post-surgery, and at 1 year after surgery.

4. *When do I report?*

Surgeries performed between July 1, 2006, and December 31, 2006, and 30-, 60-, or 90-day follow-up visits to those surgeries that took place before December 31, 2006, should have been reported before the end of the one-time extension period. Surgeries performed between January 1, 2007, and June 30, 2007, and 30-, 60-, 90-day and 1-year follow-up visits to surgeries performed on or after July 1, 2006, should have been reported before December 31, 2007. Subsequent surgeries and 30-, 60-, 90-day, and 1-year follow-up visits must be reported before June 30 for cases in the last 6 months of the preceding year and before December 31 for the first 6 months of the current year.

**Please note: June 30 and December 31 are deadlines. Surgery and follow-up reports may be submitted anytime after discharge or after the office visit until the deadline for each case.**

## 5. *What information must I report?*

You must report, to the extent that the information exists, all information requested on the form prescribed by the Indiana State Department of Health.

### **Section 1.** This information includes the **patient's**:

- Full name
- Current address
- County of residence
- Current phone number
- Date of birth and age at time of surgery or follow-up
- Sex
- Race
- Ethnicity

### **Section 2.**

#### *For the initial report:*

- Baseline BMI and waist circumference
- Whether or not the patient has had previous abdominal surgery
- Comorbidities at the time of surgery using ICD-9-CM codes (If there is insufficient space, list additional information in the comments box in Section 3.)
- Surgical diagnosis (ICD-9-CM code and description)
- Surgical procedure (CPT code and description) (If more than one procedure for morbid obesity was performed during the initial surgery, please note the code and description in the procedure box.)

#### *For follow-up reports:*

- The follow-up interval (Please check one.)
- CPT code for the initial surgery
- CPT codes for any separate surgical procedure(s) performed at the time of the initial surgery
- Follow-up (at interval) BMI and waist circumference
- Comorbidities (ICD-9-CM codes) present at time of interval follow-up (Use comments section, if necessary, for additional comorbidities.)
- Indication (yes or no) of the occurrence of death, complications of surgery, or side effects from the initial surgery
- If death, cause (ICD-10 code) and date of death
- If complication(s), ICD-9-CM code(s) and date(s) of onset
- Whether patient was hospitalized for the complication (yes or no), name of facility, length of stay, and status at time of discharge (Check one and, if status is "Other Institution", please indicate which type.)
- Whether surgery was performed for the complication(s) (yes or no) and if yes, date of surgery and CPT code(s) for the procedure(s) performed

- Whether other invasive treatment was required for the complication(s) and a description of that treatment
- If side effect(s), ICD-9-CM code(s) and date(s) of onset
- Whether patient was hospitalized for the side effect (yes or no), name of facility, length of stay, and status at time of discharge (Check one and, if status is “Other Institution”, please indicate which type.)
- Whether surgery was performed for the side effect(s) (yes or no) and if yes, date of surgery and CPT code(s) for the procedure(s) performed
- Whether other invasive treatment was required for the side effect(s) and a description of that treatment

*For all reports:*

- Surgeon’s Indiana Medical License Number
- Surgeon’s full name, address, telephone number, FAX number

### **Section 3.**

- Any additional information for Sections 1 and 2
- Any comments
- Name of the person completing the form and a daytime telephone number
- Date the form was completed

#### *6. Do we have to use the codes?*

Yes. The codes are necessary for the computing of aggregate statistics. These are the same codes that are used for billing purposes, and almost all medical offices have copies of the code books.

#### *7. We don’t know the date of onset of a complication or side effect. Can we leave that space blank?*

First, make every effort to obtain the information. Frequently, there will be information in the patient’s record indicating how long a problem has been present. You can use this information to provide an estimated date of onset. If the patient has an upcoming appointment or has had laboratory tests done, you can ask the onset date when the patient is called for a reminder or to give results. The space for the onset date may be left blank **only** if there is no information in the patient’s record to give an approximate onset date and the information cannot be obtained from the patient.